Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumers	)	WC Docket. No. 18-213
	)	

NATIONAL LIFELINE ASSOCIATION COMMENTS ON CONNECTED CARE PILOT PROGRAM NOTICE OF INQUIRY

The National Lifeline Association[1] (NaLA) respectfully submits these comments in response to the Notice of Inquiry (NOI) regarding the creation of "an experimental 'Connected Care Pilot Program' to support the delivery of … telehealth services to low-income Americans."[2] As explained herein, limiting the program to facilities-based providers would undermine the NOI's stated fundamental goal for the program, and as such, the Commission should allow resellers to participate in it as well. Additionally, while the program should be limited to low-income patients such as Medicaid recipients, the Commission should not exclude otherwise-eligible individuals who already have broadband service or those that would purchase broadband in the absence of a subsidy (which the Commission cannot know).

I. In Proposing to Exclude Resellers from the Pilot, the Commission Is Missing an Important Opportunity to Further the Fundamental Goal of the Pilot Program

The NOI states that "the *fundamental* goal of the pilot program is to improve health outcomes among low-income Americans through the use of expanded access to telehealth

[1] NaLA is the only industry trade group specifically focused on the Lifeline segment of the communications marketplace. It supports eligible telecommunications carriers (ETCs), distributors, Lifeline supporters and participants and partners with regulators to improve the program through education, cooperation and advocacy. *See* https://www.nalalifeline.org/.

[2] *See Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, FCC 18-112 (rel. Aug. 3, 2018).

services."[3] NaLA and its members support this laudable objective. Indeed, NaLA members have long viewed the Lifeline program as one vehicle for low-income consumers to get and stay connected with healthcare providers and services.[4]

However, despite setting this broad objective for the Connected Care Pilot Program, the NOI seeks comment on limiting it from the outset by "requiring broadband service providers participating in the pilot program to be facilities-based" ETCs.[5] The NOI suggests that such an approach "would be consistent with the Lifeline program … [and] that participants should be facilities-based ETCs given that one of the goals of the pilot is to increase broadband deployment in unserved and underserved areas."[6] NaLA respectfully submits that this logic is flawed and should be rejected. As an initial matter, non-facilities-based (or reseller) ETCs have participated in the Lifeline program for more than a decade, and at present, nearly 70 percent of low-income consumers in the Lifeline program are served by reseller ETCs.[7] Thus, the suggestion that the Lifeline program is limited to facilities-based ETCs is simply incorrect.

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[3] *Id.* ¶ 61 (emphasis added).

[4] For example, NaLA member Boomerang Wireless, LLC explained to the Commission in 2015 that it had entered into marketing partnerships with local Medicaid Managed Care Organizations (MCOs) so that MCOs could communicate directly with consumers signed up through the MCO through designated healthcare-related numbers. Subscribers were also able to use this free credit for communicating with their health care providers, including contacting a "Call a Nurse" program, contacting their pharmacy, and making doctors' appointments. *See Ex Parte* Letter of Boomerang Wireless, LLC, WC Docket No. 09-197 (filed Feb. 9, 2015). Unfortunately, however, partnerships like these have been stymied by the Commission's lack of action on federal ETC petitions, including Boomerang's, which has been pending for nearly eight years.

[5] NOI ¶ 37.

[6] *Id*.

[7] *See* Comments of the National Lifeline Association, WC Docket No. 17-287 et al., 7 (filed Feb. 21, 2018).

Moreover, as a result of their experiences and documented success in the Lifeline program, resellers (and in particular wireless resellers – mobile virtual network operators or MVNOs) have a unique expertise in locating, enrolling and serving the same communities that the Connected Care Pilot Program seeks to serve, i.e., low-income consumers and veterans.[8] If the Commission wants to achieve the fundamental goal of improving health outcomes for low-income individuals, it should leverage resellers that can utilize existing networks, especially wireless networks, to make telehealth services more accessible and affordable.[9] Such an approach would not only promote "services and applications delivered directly to patients outside of brick-and-mortar health care facilities," but would also facilitate remote monitoring and other innovative telehealth services using wireless networks that function beyond the walls of a consumer's home.[10]

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[8] *See* NOI ¶ 28.

[9] If, on the other hand, the Commission is more concerned with advancing the proposed secondary goal in the NOI of "increas[ing] broadband deployment in unserved and underserved areas," NOI ¶ 37, then it may be appropriate to limit the Connected Care Pilot Program to facilities-based ETCs. However, any such program would need to be limited only to areas where broadband service is currently not available to incentivize deployment. Otherwise, program funds could be used to overbuild in areas where broadband networks already exist and result in "duplication of other Commission initiatives" such as the Rural Health Care Program and the Connect2Health Task Force. *See* NOI ¶ 23. Additionally, the pilot program would need to be in place for much longer than the two to three years proposed in the NOI, because, as the Commission acknowledges, network deployments take time. *See id*. ¶ 51. Moreover, allocating pilot program funds solely for the purpose of network deployment would be an inefficient use of resources. As the NOI notes, "a remote patient monitoring pilot project with 100 patient participants would cost no more than $2.4 million over three years," while a program that focuses on network deployments or upgrades could cost $20 million per project. *See id*. ¶ 49. Thus, a better use of pilot program funds would be to make services affordable for low-income individuals where networks already exist.

[10] Indeed, the program at the University of Mississippi Medical Center that allowed doctors to remotely monitor diabetes patients in rural Mississippi via tablet computers was accomplished through a partnership with C Spire, a wireless provider. *See* Neil Versel, "Mississippi Telehealth, Remote Monitoring Pays Dividends for Diabetics," Med City News (Sept. 13, 2016), https://medcitynews.com/2016/09/mississippi-telehealth-remote-monitoring/.

II. In Order to Efficiently Meet its Fundamental Goal, the Pilot Should Serve Only Low-Income Subscribers

The NOI also seeks comment on "limiting the participating health care providers' use of the pilot program funding to Medicaid-eligible patients, as well as veterans who qualify based on income for cost-free health care benefits through the Department of Veterans Affairs (VA)."[11] NaLA agrees that funds from a Connected Care Pilot Program should be available exclusively for low-income patients, and Medicaid participation in particular would serve as a reliable means of verifying a consumer's eligibility for the program. Such an approach would maximize the efficient distribution of program resources. However, the Commission should not adopt the suggestion in the NOI that the program exclude "participants who already have broadband or would purchase it in the absence of a subsidy."[12] Indeed, it would be impossible to effectively administer a program that attempts to make support available only to those consumers that have not yet adopted broadband (however that would be defined) or who would not purchase telehealth services in the absence of a subsidy (which is not knowable). As the NOI acknowledges, there may be instances in which a low-income household subscribes to broadband service "intermittently" or has already adopted broadband but requires "higher speed connectivity to access bandwidth-intensive telehealth services."[13] These consumers, if otherwise

[11] NOI ¶ 39. The NOI suggests that "focusing on Medicaid patients and veterans who qualify for cost-free health care through the VA based on income would ensure that pilot program funds are appropriately targeted to low-income individuals, while also relieving participating hospitals and clinics of the burdens that would otherwise be associated with determining whether individual patients receiving broadband services funded by the pilot program qualify as low-income." *Id*.

[12] *Id*. ¶ 40.

[13] *Id*.

eligible for the Connected Care Pilot Program, are no less in need of support, and therefore should not be excluded from the program.

CONCLUSION

For the reasons explained herein, NaLA respectfully requests that the Commission design any Connected Care Pilot Program consistent with these comments to most effectively and efficiently meet the program goals.

Respectfully submitted,

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